Chapter 3

Criticism of the bill and counterarguments

3.1 The committee received comment from several organisations that the modelling undertaken by the Centre for Health Economics Research and Evaluation (CHERE) was inadequate and incorrect, and that the bill's effect will be to put important medical procedures out of the financial reach of those who need them. This chapter discusses these claims and the counterarguments.

The Australian Medical Association's criticism of the CHERE report

3.2 In its submission to this inquiry, the Australian Medical Association (AMA) criticised various aspects of the CHERE report. It argued that the CHERE analysis:

- wrongly assumes that 2003 Medicare data on medical fees charged for certain Medicare Benefits Schedule items reflects the actual fees charged by doctors at that time. This data does not take account of fees charged for services not covered by, and therefore not reported to, Medicare in 2003;
- fails to understand the effect of compositional change on 'average fees'. The AMA emphasises that the rate of price increase reflects the changing mix of services being delivered annually, 'spurred by advances in technology'. Accordingly, the CHERE's analysis that the Extended Medicare Safety Net (EMSN) was directly responsible for a 2.9 per cent increase in fees per year 'is incorrect. The difference between government rebates and the real increase in the cost of delivering medical services over time was not taken into account;
- completely ignores practice costs and treats the increase in average fees as a proxy for doctors' incomes. The AMA stresses that the income doctors generate from providing professional medical services must service their practice costs, which may involve infrastructure costs in the case of assisted reproductive technology (ART); and
- wrongly uses Consumer Price Index (CPI) as a benchmark and implies that any increase in fees is 'excessive'. However, 'the rate of increase in CPI bears no relationship at all to the costs of medical practice'. The AMA suggested that the Average Wage Index would provide a more appropriate benchmark.[1]

3.3 The AMA's submission also queried the Government's modelling of the effect of the bill. In particular, it noted that the draft Ministerial determination provides EMSN caps for services that are provided in hospital: EMSN benefits are only payable for services rendered out of hospital.

---

1 Australian Medical Association, *Submission 1*, p. 4.

3.4 The AMA recommended that the bill be amended to include a provision requiring the Minister to consult with the relevant medical groups about their fee structures and any proposal to introduce and/or change an EMSN cap before making determinations to impose EMSN caps on medical services.[2]

DoHA's response

3.5 In its submission, the Department of Health and Ageing (DoHA) responded to several of the AMA's criticisms. It acknowledged the Association's recommendation that the bill be amended to include the provision that the Minister should consult with the medical profession prior to the introduction of the EMSN benefit caps (paragraph 3.4). However, it responded:

> …section 17 of the LIA Act [*Legislative Instruments Act 2003*] sets out that before a rulemaker makes a legislative instrument, and particularly where the proposed instrument is likely to have a substantial impact on business or competition that appropriate consultation has taken place. The LIA Act also requires that the explanatory statement to the instrument includes a description of the consultation undertaken, or an explanation as to why no consultation has occurred.[3]

3.6 DoHA has also responded to the AMA's criticism that the government's modelling wrongly includes some EMSN benefits for in-hospital services (paragraph 3.3). It noted that for the few obstetric services that are provided out of hospital:

> EMSN benefit caps have been placed on these items to ensure that there is no perverse financial incentive to provide any services on an out-of-hospital basis. Although, these items will have EMSN benefit caps, the calculation of savings does not assume any savings from applying a cap to these items or the payment of EMSN benefits for these items, as current EMSN expenditure in this area is very small.[4]

3.7 Of the criticism that CHERE had wrongly used CPI data as a benchmark (paragraph 3.2), the Department gave the following response:

> CHERE used CPI to allow the fees charged data to be presented and analysed in 'real terms' that is, with the impact of inflation removed. This is standard practice when analysing data. CPI was not used as a benchmark for assessing whether the increases in the fees charged were reasonable as asserted by the AMA. The analysis did not examine whether the general increase in fees charged was acceptable or 'excessive' but rather whether the fees increased as a result of the EMSN.[5]

---

2 Australian Medical Association, *Submission 1*, p. 4.

3 Department of Health and Ageing, *Submission 4*, p. 21.

4 Department of Health and Ageing, *Submission 4*, p. 31.

5 Department of Health and Ageing, *Submission 4*, p. 53.

CHERE's response

3.8 CHERE's EMSN Review Project Team has also provided the committee with a rejoinder to the AMA's criticisms of its review. Most fundamentally, the CHERE Team corrected the AMA's claim that the CHERE analysis compared 2003 and 2007 data. Rather, the analysis examined changes over the period 2000 to 2008 and in particular, whether the trend between these years differed from that between 2004 and 2008.

3.9 Of the AMA's criticism that CHERE's analysis fails to take into account services that are not covered by Medicare prior to the introduction of the EMSN, the CHERE Team responded:

> This is not true. The analysis incorporates our best estimate of such charges prior to 2004. It should be noted that we sought more information about these charges from the AMA, but we were informed that there were no data available.[6]

3.10 The CHERE Team described as 'incorrect' the AMA's claim that its analysis takes no account of the real increases in the cost of delivering services, and the shift to more complex services, over time. It noted that 'considerable effort' had gone into its analysis to establish a causal link between the EMSN and the observed changes in trends. To this end, the analysis:

- compared in-hospital with out of hospital results to control for general changes such as increases in the cost of practice; and
- included changes to the Medicare Benefits Schedule to control for new Medicare items, changes in Medicare benefits and greater complexity of patients.[7]

3.11 Finally, the CHERE Team also took issue with the AMA's claim that their analysis had used the CPI as a benchmark and that the fee increases above the rate of CPI were 'excessive'. While the CHERE analysis did use the CPI to adjust fees and benefits, 'we simply (and correctly) reported that the results obtained were over and above the rate of inflation'.[8]

---

6 Centre for Health Economics Research and Evaluation, EMSN Review Project Team, *Submission 5*, p. 1.

7 Centre for Health Economics Research and Evaluation, EMSN Review Project Team, *Submission 5*, p. 1.

8 Centre for Health Economics Research and Evaluation, EMSN Review Project Team, *Submission 5*, p. 1.

Committee view

3.12 The committee believes that the Department and the CHERE EMSN Review Team have adequately addressed each of the AMA's criticisms of the EMSN Review's analysis.

Criticism of the bill

3.13 Among the various medical services for which the bill will cap public subsidy, there was most concern at the affordability and access for patients to assisted reproductive technology (ART) services. The committee took evidence from several organisations concerned that the proposal to cap the EMSN will make in vitro fertilisation (IVF) procedures unaffordable. Underpinning these concerns was an objection to the methodology and the findings of the CHERE report, and an insistence that the higher cost of IVF procedures principally reflects the higher level of investment in a higher quality service.

3.14 The committee has had recent experience with inquiries into ART and members of the committee have adopted a general line of argument that has been supportive of ART procedures. However, in this instance, where there is tension between supporting access to services and significant escalation of costs to the public purse, the committee recognises there is a significant dilemma.

The out of pocket costs for patients

3.15 The principal concern of witnesses representing IVF, obstetric and ophthalmological services is that the bill will financially disadvantage their patients. AccessAustralia, an independent charity established to raise community awareness about infertility issues, wrote in its submission that if the government's concern is excessive doctors' fees, the matter should be addresses with the doctors concerned. It claimed that the bill would penalise all families who need IVF, which will mean an increase in out-of-pocket costs of $3000 per cycle.[9]

3.16 Dr Molloy of the IVF Directors Group explained that while recent EMSN expenditure on obstetrics had not greatly inflated patient costs, the bill's proposals will cause financial disadvantage:

> My understanding of the data over the last two years is that the average safety net exposure, around Australia, as a fee for the management of a pregnancy for nine months is actually only $1,700…That fee had only risen by…about $100 a year over the time of the safety net. [T]he average working obstetrician looking after the average patient out there was only charging about $1,600 or $1,700. Now 100 per cent of these women are going to be worse off because the caps have been set so low in the obstetrics section of this document that most of them will not even get to

9 AccessAustralia, *Submission 8*, p. 1. See also Mrs Anne Hill, *Proof Committee Hansard*, 9 July 2009, p. 44.

> the threshold to access the safety net. So patients are going to be enormously disadvantaged, even if they are going to the 25 per cent cheapest obstetricians in this country.[10]

3.17 The AMA expressed also concern that the caps may be set at a level which does not trigger the safety net threshold. Dr Andrew Pesce, President of the AMA and the former President of the National Association of Specialist Obstetricians and Gynaecologists (NASOG), told the committee:

> You have to remember that the patients have to meet the first $1,100 per calendar year in out-of-pocket expenses before the safety net is triggered. Because the caps have been set at a fairly low level, I find it hard to see that a pregnancy in itself is going to trigger any safety net support. It is not just a question of capping; it is a question of capping in combination with a trigger threshold level for safety net support. If you are going to be, for all intents and purposes, removing safety net support, then you need to recognise either the patient is going to be a lot worse off or you have to make up for it in some other way.[11]

3.18 In its submission to this inquiry, the Australian Society of Ophthalmologists (ASO) noted that the Medicare reimbursement for cataract surgery as of November 2009 would be reduced from $623.70 to $307.20. It identified the 'most concerning effect' of this reduction as the 'economic viability of the delivery of eye care to rural and remote centres'. The ASO was unequivocal: if the Medicare rebate is cut by 50 per cent, the cost of cataract surgery will be 'beyond the reach' of the 'average Australian'.[12]

Doctors' fees

3.19 Chapter 2 noted that the CHERE report had found that between 2003 and 2008, the fees charged by obstetricians for in-hospital services reduced by six per cent while the fees charged for out of hospital services increased by 267 per cent. In the context of these data, the Minister explained that 'some specialists have taken advantage of this arrangement [the EMSN] to increase their fees and their incomes, unfortunately with no particular benefit to the patient'.[13]

3.20 Several witnesses took exception to this interpretation. Dr David Molloy, Deputy Chairman of the IVF Directors Group of Australia and New Zealand, explained that the out of hospital fee increases do not reflect doctors' higher incomes. He told the committee that:

---

10 Dr David Molloy, *Proof Committee Hansard*, 14 July 2009, p. 39.

11 Dr Andrew Pesce, *Proof Committee Hansard*, 14 July 2009, p. 40.

12 Australian Society of Ophthalmologists, *Submission 6*, p. 3.

13 The Hon. Nicola Roxon, Second Reading Speech, *House of Representatives Hansard*, 15 June 2009, p. 5920.

> IVF item numbers are basically global item numbers: they cover 30 days provision of services for everything that the unit does—doctors' fees, ultrasound, pathology, scientific fees and psychological counselling are all bundled into one fee. Then, because of the Medicare Australia Act, it is put against a doctor's provider number. That is why, when the services increased due to increased access and affordability between 2004 and 2009, those top 10 doctors that the department presented to you had an increase against their names. It was basically the billing for a global item number, on behalf of their clinic, against their provider number. It has nothing to do with their personal incomes. It is like pathologists or radiologists billing on behalf of these quite large practices.[14]

3.21 Associate Professor Peter Illingworth from the Fertility Society of Australia also stressed that the figures the government has quoted on payments to doctors do not reflect a doctor's income. The fees contribute to various other costs besides income, including money:

> …for the staff to deliver the complex treatments, the scientific equipment, the culture media and the consumables used in the laboratories, as well as the ongoing research that is required to ensure that technology and results remain the best in the world. For every doctor who is involved in IVF, there are at least 10 scientists, nurses and counsellors delivering IVF care to patients. Around Australia, in excess of 2,000 employees work in the provision of IVF patient services.[15]

The booking fee

3.22 One explanation for the sharp increase in the average fee for ART services is that a booking fee for these services, which was in place prior to the EMSN, has been included in fees charged by Medicare.

3.23 Dr Pesce, President of the AMA and himself an obstetrician, gave the following context:

> ...before the safety net [the EMSN]…we just asked them [patients] to pay a booking fee. What that did was allow us to get our gap fee upfront, and we did not have to chase the patient later…The patient paid a single expense that allowed them to cover the gap, and I knew that I had no bad debts at the end of it.
>
> When the safety net came in, I had the opportunity to raise my antenatal visit charges to take advantage of that underpinning by the government. The patients knew that they were committed to this expense; the government had said that out-of-hospital services would be underpinned by a safety net…

14 Dr David Molloy, *Proof Committee Hansard*, 14 July 2009, pp. 32–33.

15 Associate Professor Peter Illingworth, *Proof Committee Hansard*, 9 July 2009, p. 37.

> In 12 months, all of a sudden Medicare expenditure on private obstetrics doubled because the previous amount, which had not been booked to Medicare, was now being booked to Medicare…It was not because doctors put up their fees; it was because they transferred an out-of-pocket expense of the patient to something that the government had said, 'Yes, it's available.' That has not been adequately explained or understood and, unfortunately, the statement that obstetricians' incomes have gone up by 267 per cent is just plain wrong.[16]

3.24 Associate Professor Illingworth also noted that in previous assessments of the cost of IVF services, DoHA had not factored in the booking fee that patients were required to pay prior to the introduction of the EMSN. He told the committee that part of the reason for the steep rise in IVF fees reported by the government was that these booking fees had not been taken into account.[17]

The drivers of higher costs for ART services

3.25 Apart from these process-based issues, the committee was also alerted to the higher technological and quality assurance costs associated with Australia's world class IVF services. Dr Hilary Joyce, the current President of NASOG argued that the CHERE report had failed to identify the value of benefits derived through better access to both obstetric and ART services as an offset to the cost of the EMSN. She noted that in ART, Australia has:

> …the world's best outcomes at about half the cost in the USA and less than two thirds of the cost in the UK. Far from our medical practitioners rorting the system they provide services at the top level of outcomes for costs below the OECD average.[18]

3.26 In terms of what has been driving the higher cost of ART services in Australia, Dr Joyce explained that:

> In both obstetric and fertility services, we have seen significant growth in the number of services being delivered. The number of children born has increased from a low of around 240,000 in 2003 to around 280,000 in 2008. The increase of 10 years in the average age of women and men having their first child since the middle of the last century, driven mainly by social and economic factors, is a driver of increased utilisation of fertility treatments.
>
> …
>
> Better access to services and treatment has certainly driven growth in costs to the Medicare safety net, but it has seen a corresponding improvement in

16 Dr Andrew Pesce, *Proof Committee Hansard*, 14 July 2009, pp. 38–39.

17 Associate Professor Peter Illingworth, *Proof Committee Hansard*, 9 July 2009, p. 38.

18 Dr Hilary Joyce, *Proof Committee Hansard*, 14 July 2009, p. 32.
See also Associate Professor Peter Illingworth, *Proof Committee Hansard*, 15 June 2009, p. 37.

> outcomes for those patients who have been unable to gain access to appropriate treatments before the implementation of the safety net.[19]

3.27 The committee is aware that a key yardstick of the quality of IVF services in Australia is the low rate of multiple embryo transfers. However, it does not believe that the maintenance of this high standard would be compromised by the proposed changes to the EMSN.

3.28 Dr Molloy told the committee that there are higher costs involved in ensuring single embryo transfers. He explained that following a 'major leap' in multiple IVF pregnancies in 2000–2001:

> We had to completely retool our laboratories for a completely different way of growing embryos…The retooling of the laboratories, which has actually continued over the last eight years, has been extremely expensive. We have also seen an expansion of services called ICSI, where we inject sperm into eggs, which has become the gold standard treatment. This ties up a scientist for most of an afternoon with a quarter-of-a-million-dollar microscope. Also, we have had to purchase more freezers and better storage facilities because we are freezing more embryos, as we have dropped down to only putting one embryo back under optimal circumstances. There has been a large flow-on of costs for that as well. The other point I would make is that our compliance costs with our auditing programs and quality assurance programs have dramatically increased. Units like…mine now have a full-time quality assurance officer, and most of us have employed such a person in perhaps the last three years. That is a high level position to oversee quality management in each unit. [20]

3.29 Associate Professor Illingworth told the committee that IVF clinics in Australia are required to comply with a level of regulation that is 'unparalleled in Australian medical practice'. He also noted that while Australia is a world leader in the transfer of one embryo at a time:

> We are very concerned that increased cost burdens for patients will cause increasing pressure to return to days of multiple embryo transfers, with adverse consequences for the health of the children and increased cost of natal care.[21]

DoHA's response to these concerns

3.30 The Department of Health and Ageing made a detailed submission to the committee following the public hearings, partly to address the various concerns raised with the bill. This section details those responses.

---

19 Dr Peter Hilary Joyce, *Proof Committee Hansard*, 14 July 2009, p. 32.

20 Dr David Molloy, *Proof Committee Hansard*, 14 July 2009, p. 36.

21 Associate Professor Peter Illingworth, *Proof Committee Hansard*, 9 July 2009, p. 37.

Higher costs for ART services

3.31 On the broad question of what is driving higher costs for ART services, the Department acknowledged that MBS payments for services provided by ART doctors 'does not equal the personal income of these doctors and there are significant practice costs in providing ART'. However:

> …the payments do not include patient co-payments, payments for services that are not remunerated through the MBS, or facility and accommodation fees that are paid to the ART clinics for in-hospital ART services.[22]

3.32 DoHA's submission considered whether the higher fees charged by highest decile of ART doctors by Medicare derived income was due to an increase in the number of services they offered. Between 2005 and 2008, the average patient out of pocket cost for Medicare funded ART services by these doctors increased by $380 000 per doctor. DoHA observed that while there has been an increase in the number of ART services, 'there has been a similar increase in the number of ART doctors'. Accordingly, it concluded that the increase in fees per doctor is not a result of significant increases in the number of services provided by these doctors.[23]

3.33 DoHA questioned stakeholders' claims that higher ART costs reflected the burden of accreditation and compliance. It cited a study, published in 2009, which found 'no clear relationship' between the level of regulation of public funding of ART and the cost of an episode of ART treatment.[24]

3.34 The Department also doubted the credence of the AMA's claim that higher average ART fees reflect the fact that IVF is a uniquely capital and labour intensive area of health care. It gave the following explanation:

> There are numerous complex diagnostic and therapeutic procedures that are labour intensive and require regular large capital investments due to technological developments, yet ART is the only area to have systematically increased its fees to such a large extent.
>
> …
>
> Prima facie, costs of IVF clinics should be increasing consistently with other industries, particularly the medical sector. If they are not, then the IVF providers should be able to identify why not and provide information on these cost drivers. Most efficient big businesses should be able to identify their cost drivers and provide evidence on how these drivers have moved outside normal market increases. It is also interesting to note that IVF clinics are attracting the interest of large financial investment

22 Department of Health and Ageing, *Submission 4*, p. 33.

23 Department of Health and Ageing, *Submission 4*, p. 33.

24 Department of Health and Ageing, *Submission 4*, p. 34. The cited study is: Georgina M. Chambers, Elizabeth A. Sullivan, Osamu Ishihara, Michael G. Chapman, G. David Adamson, 'The economic impact of assisted reproductive technology: a review of selected developed countries', *Fertility and Sterility*, vol. 91(6), pp. 2281–2294, 2009.

> corporations including Macquarie Bank, ABN Amro and Quadrant Private Equity all of which have invested in IVF clinics since the introduction of the EMSN. This indicates that ART is a very profitable industry.[25]

3.35 Somewhat tersely, the Department concluded: 'what is unique about ART is not the intensity of capital and labour investment, but only the systematic increases in fees charged to patients to take advantage of the unlimited government subsidy'.[26]

Out of pocket costs for IVF patients

3.36 In similar vein, DoHA has argued that 'the majority of patents' needing ART procedures will not be affected by the legislation 'if doctors' charges remain at current levels'. It noted that a patient receiving a typical cycle of treatment billed at the median level of $6000 'should not be worse off'.[27] Chapter 2 (paragraph 2.22) noted the Minister's comments along the same lines. DoHA described as 'incorrect' the claim that patients' out of pocket costs would increase from $1000 to $3000 per cycle as a result of the Budget measure.

The booking fee

3.37 DoHA refuted the idea that the inclusion of the booking fee (used for ART services prior to the introduction of the EMSN) into the Medicare fees could be responsible for the sharp increase in either ART or obstetric average fees. In terms of obstetric services, DoHA claimed that 'it is reasonable to assume' that the majority of any booking fee charged by doctors for the out of hospital component of their service was largely included in their out of hospital fee by 2005.[28] In terms of ART services, DoHA argued that:

> …there has been an MBS funded item for the planning and management of an ART cycle since 1990 and in any case it is insufficient explanation for ongoing significant increases in the fees charged five years after the EMSN was introduced.[29]

3.38 On the issue of the booking fee for ART services prior to the introduction of the EMSN, and the claim that CHERE's analysis had failed to include this fee, the Department responded:

> …that CHERE conducted a sensitivity analysis for ART services to assess the impact of the EMSN on out-of-pocket costs including a booking fee. During consultations with the AMA and other professional groups, representatives from NASOG informed the consultants that there was a

25 Department of Health and Ageing, *Submission 4*, pp. 34–35.

26 Department of Health and Ageing, *Submission 4*, p. 35.

27 Department of Health and Ageing, *Submission 4*, p. 38.

28 Department of Health and Ageing, *Submission 4*, p. 25.

29 Department of Health and Ageing, *Submission 4*, p. 16.

> non-Medicare booking fee for ART services prior to the introduction of the EMSN. It should be noted that the Department does not have evidence of the existence of a booking fee being charged to ART patients prior to the EMSN. In fact there has been a Medicare item for the planning and management of an ART cycle (commonly referred to as the 'booking fee') in the MBS since 1990. The sensitivity analysis used two scenarios - where a booking fee was charged to ART patients prior to the EMSN and the situation where no booking fee was charged. Assuming that there was a booking fee, the EMSN Review report found that for every dollar spent on the EMSN for ART services, 31 cents went to higher fees and 69 cents went to reducing out-of pocket costs for patients. If it is assumed that there is no booking fee, the CHERE results indicated that for every EMSN dollar, 52 cents went to providers' fee and 48 cents went to assisting patients with their out-of-pocket costs.[30]

Committee view

3.39 The committee is satisfied that the Department has adequately addressed to the concerns put to the committee by various stakeholders. It recognises the difficulty of establishing a causal link between an increase in average fees for medical services and the range of factors that may have contributed to higher costs. Indeed, it is highly likely that recent increases in average fees for the services that the government proposes to cap are the result of several factors. However, the fact that the cost of ART and obstetric services has exceeded most other complex diagnostic and therapeutic procedures suggests that there is more at play than high labour, infrastructure, regulatory and quality control costs.

3.40 Above all, the committee emphasises that the current pattern of expenditure on the EMSN is unsustainable. Capping the most inflationary items will have the desired effect of curtailing public expenditure on the extended safety net. Whether it also restrains average fees for these services remains to be seen. The committee believes, however, that the introduction of a cap on the EMSN subsidy will send the right incentives to the medical profession: they must compete to provide a high quality of service as well as providing value for money for their patients. In terms of ART procedures, the committee reiterates DoHA's observation: if doctors do not hike their fees, patients seeking typical procedures should not be financially disadvantaged by the bill's measures.

Lack of consultation

3.41 In his evidence to the committee, Mr David Learmonth, Deputy Secretary of DoHA, told the committee that the Department had been in consultation with the AMA and NASOG about the safety net 'for some years'. He noted that as part of these discussions:

---

30 Department of Health and Ageing, *Submission 4*, p. 38.

> There were, I think, undertakings for expressions of restraint, so at the end of the day some of the issues about fee increases and opportunities to take issue with their reasonableness, or their apparent unreasonableness, have existed in consultations over the last couple of years between us and the AMA and some of the craft groups.[31]

3.42 DoHA's submission noted that the Department 'is continuing to work with the profession' leading up to the implementation of the measure. It referred to 'currently working with' the ART profession including members of the IVF Directors Group and future work with obstetrician groups on the new items for obstetric services.[32]

3.43 However, the committee is aware that peak professional groups are frustrated with what they view as DoHA's inadequate consultation in the lead up to the bill's introduction. Dr Joyce of NASOG told the committee that the AMA had had a meeting with representatives of CHERE in March of this year. During the meeting, CHERE representatives sought input from 'specialty representatives' and 'undertook to meet with them to review progress in the report prior to submission to the government of the final report'. Dr Joyce also noted that CHERE had indicated that the report could not be completed until July 2009.[33]

3.44 Dr Pesce corroborated this evidence, with reference to a meeting between the AMA and DoHA officials in February this year. He gave the committee a sketch of the discussion. DoHA officials told the AMA:

> 'This is going to take a long time. It's very complex. We don't anticipate we're going to publish the report before July.' We asked: 'When is this going to be ready? Is it going to be used in the budget process?'…They said, 'There is no way this will be done before July.' We said: 'To avoid us having to go out and potentially criticise anything that we see has been done incorrectly, would you give us the opportunity to have a look at your draft report? We can't tell you what to write, but at least give us a chance to have input into what we see you're doing and give you some feedback.' They said, 'Yes, we'll be able to do that.' Then all of a sudden we were overtaken by events, the report was published in time for the budget and we had not been consulted.[34]

3.45 Other organisations also expressed their disappointment at not being consulted. The ASO wrote its submission:

> To date the basis on which the decision to reduce funding for cataract surgery to such a degree is unclear and has not been disclosed. There was no consultation with health care providers or consumers prior to the announcement of this decision. The result of this lack of consultation is that

---

31 Mr David Learmonth, *Proof Committee Hansard*, 14 July 2009, p. 27.

32 Department of Health and Ageing, *Submission 4*, p. 25.

33 Dr Hilary Joyce, *Proof Committee Hansard*, 14 July 2009, p. 31.

34 Dr Andrew Pesce, *Proof Committee Hansard*, 14 July 2009, p. 41.

> a decision has been taken with a number of adverse consequences for the community. These consequences have wide ramification for the health of the aging population.[35]

3.46 In its submission, DoHA responded to the AMA's criticism that the Department had failed to adequately consult in the lead up to the bill being introduced into Parliament. It explained that the report—to be tabled in Parliament—was embargoed and could not be publicly released. Further:

> CHERE provided the AMA with a summary of the issues discussed at their meeting and the AMA agreed that this was an accurate representation of the discussion. This summary was included in the EMSN Review report as an attachment and posted on the Department's website on the day that the report was tabled in Parliament. The Department has checked with CHERE whether there was any mention at this meeting of the timeframe of July for completion of the report. CHERE has confirmed that a July report date was not advised. Their contract required the report to be complete by early April 2009.[36]

Committee view

3.47 Notwithstanding the Department's explanation, the committee is concerned that key stakeholders are dissatisfied with the recent consultation process. It is a legislative requirement that the Minister initiate an independent review of the EMSN, and it is only proper that the findings of this review should contribute to the executive's decision-making process in any amendments it makes to the safety net. In future, the process will work through legislative instruments that are based on parliamentary scrutiny and any variation to the cap will be reliant on effective consultation. The committee urges DoHA to ensure that the methodology and key findings of future reviews of the EMSN are thoroughly discussed with key stakeholders before legislation is brought before Parliament.

Recommendation

3.48 The committee recommends that the bill be passed.

Senator Claire Moore
Committee Chair

August 2009

35 Australian Society of Ophthalmologists, *Submission 6*, p. 5.

36 Department of Health and Ageing, *Submission 4*, p. 53.